MDR Tracking Number: M5-04-1359-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on January 15, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that therapeutic exercises, office visits, muscle testing, myofascial release, joint mobilization, group therapeutic procedures, ankle ROM and physical performance test were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 5, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission.

- CPT Code 97750-MT (7 units total) for dates of service 04/07/03 and 04/08/03. Per the 1996 Medical Fee Guideline, Medicine Ground Rule, (I)(E)(3) reimbursement in the amount of $251.50 ($43.00 x 7 = $301.00 - $49.50, carrier payment) is recommended.

- CPT Code 99214 for date of service 04/08/03. Per the 1996 Medical Fee Guideline, Evaluation & Management (VI)(B) reimbursement in the amount of $71.00 is recommended.

- CPT Code 95851 for date of service 04/08/03. Per the 1996 Medical Fee Guideline, Medicine Ground Rule, (I)(E)(4) reimbursement in the amount of $36.00 is recommended

- CPT Code 99213 (4) for dates of service 04/14/03 through 04/28/03. Per the 1996 Medical Fee Guideline, Evaluation & Management (VI)(B) reimbursement in the amount of $192.00 ($48.00 x 4) is recommended.

- CPT Code 97110 for dates of service 04/11/03 through 04/28/03. Consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation. The MRD declines to order payment because the requestor did not identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement is not recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 04/07/03 through 04/28/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 30th day of September 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO Decision

Envoy Medical Systems, LP

1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

March 31, 2004

Re: IRO Case # M5-04-1359

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective

January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured his left foot on ___ when a 15,000 pound piece of metal fell on his foot. He was initially treated with physical therapy, and he returned to work after three months. He continued to have left ankle pain and sought chiropractic treatment.

Requested Service(s)
Therap exercises, ovs, muscle testing, myofascial release, jnt mobilztn, grp therap proc, ankle ROM, perf test 4/25/03-6/24/03

Decision
I agree with the carrier's decision to deny the requested services.

Rationale
Based on the records provided for this review, he patient had had an extensive course of physical therapy and chiropractic treatment prior to the dates in dispute without documented relief of his symptoms or improved function. Some 22 sessions of physical therapy, therapeutic exercises and chiropractic treatment were performed prior to the dates in dispute.
Daily SOAP notes from the treating D.C. are repetitive in that the patient's subjective complaints and objective findings never changed. On his initial visit on 2/27/03, the patient's VAS was 5/10 and varied little during subsequent months of treatment. On 6/24/03 his VAS was still 5/10. On 6/24/03, after months of extensive treatment, the patient said that his "pain is higher."

> I question the patient's effort on several of the tests performed. The treating D.C.'s notes on several occasions report a "low effort" while testing or performing therapeutic exercises. Therefore, I question the validity of the performance tests and range of motion tests. The failure of conservative therapy does not support the medical necessity of further non-effective therapy. Treatment was over utilized and inappropriate. The records provided suggest that the patient plateaued in a diminished condition prior to the dates in dispute.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____

Daniel Y. Chin, for GP